

Preliminary Draft

**Substance Abuse Services
Chapter**

**District of Columbia
State Health Systems Plan**

**State Health Planning and
Development Agency
District of Columbia
Department of Health**

Substance Abuse Services – Preliminary Draft

SUBSTANCE ABUSE SERVICES

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SUBSTANCE ABUSE SERVICES

I. INTRODUCTION

Substance abuse has been an intractable and pervasive health problem in the District of Columbia, as well as across the nation. The effects of substance abuse have led to family disruption, homelessness, excess mortality and morbidity, increased criminal activity and violence, and a host of other negative forces that erode the vitality and civility of urban and rural living today. The cost of health care, law enforcement, crime, accidents, lost productivity, and human suffering due to substance abuse has taken quite a toll.

Substance abuse is most commonly defined as a destructive pattern of use and dependence on alcohol, drugs or tobacco that often leads to clinically significant impairment or distress, as manifested by three or more of the following criteria in the same 12-month period:

- a need to increase the amount of the substance to achieve intoxication
- an inability to limit or quit using the substance, taking the substance to avoid withdrawal symptoms
- frequent intoxication or withdrawal symptoms which interfere with major obligations at work, school or home
- preoccupation with the substance, neglecting important social, occupational and or recreational activities
- continued use of the substance despite knowledge of its negative impact

Alcohol is the most commonly abused drug with heavy or binge drinking increasing the risk of cirrhosis, hepatitis B and C, and other liver disorders. Tobacco use is associated with nearly 20 percent of all mortality, making its elimination the single most effective intervention strategy to reduce deaths. Smoking cigarettes causes heart disease, stroke, cancer, chronic obstructive pulmonary disease and other health problems. Women's consumption or use of alcohol, tobacco, or other drugs during pregnancy contributes to low birth weight, mental retardation, and developmental delays.

The relationship between injection drug use and HIV transmission is well known. Injection drug use is also associated with hepatitis B and C, heart failure, convulsions and seizures, and spread of STDs. Also, unemployment, substance abuse, and child abuse have been found to be interrelated

Approximately 60,000 District residents—more than one in ten – are addicted to illegal drugs or alcohol. Of the 1.2 million emergency room visits in the District, 40 percent are related to drug or alcohol abuse. Fifty percent of the reported motor vehicle accidents in the District are associated with substance abuse. Nearly fifteen percent of new mothers report having used illicit drugs during pregnancy. Eighty- five percent of the foster care

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placements are connected with substance abuse. Twenty- seven percent of the cumulative- reported AIDS cases in the District are related to intravenous drug use.¹

Substance abuse services consist of those programs that assist District residents in preventing and treating the abuse of drugs, alcohol and tobacco. These programs, which are listed in section IV of this chapter, are provided by various public and private sector entities, which offer services in outpatient, residential or inpatient settings. Many of the clients served these programs are court referrals from the criminal justice system. Many of the District's employers offer an Employee Assistance Program (EAP) to assist their employees in addressing substance abuse problems so that they can retain their jobs.

II. BACKGROUND AND TRENDS

History

The Addiction Prevention and Recovery Administration (APRA), formerly the Alcohol and Drug Abuse Services Administration (ADASA), is the single state agency in the District of Columbia responsible for regulating and ensuring the provision of services for the prevention and treatment of alcohol and other drug addictions. Its mission is to prevent the use of alcohol, tobacco and other drugs (ATOD); to identify treat and rehabilitate District residents who are addicted; and to develop, promote and enforce the highest quality of regulatory standards of services related to ATOD.

Historically, APRA has been the major provider of substance abuse treatment services in the District of Columbia with a primary focus on opiate addiction and the treatment of that addiction with methadone. However, during the past decade APRA has shifted from direct operation of treatment clinics and programs to contracting out those programs to the private sector.

APRA also was designated as the single state agency during this period with the primary responsibility for administering the Substance Abuse Prevention and Treatment (SAPT) Block Grant and most of the Federal categorical grants for substance abuse in the District.

This shift in focus required APRA to reorganize its administrative structure from a direct service provider line agency to an agency responsible for citywide strategic planning, regulatory development and enforcement, and policy development. APRA is also responsible for ongoing needs assessment for substance abuse prevention and treatment and to identify broad trends with implications for program planning. The following is discussion of national and local trends based on national data studies and the District's 2000 Household Survey, which was designed and funded by APRA.

National Trends

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Epidemiological descriptions of drug abuse in the U.S. in the last three decades have primarily used prevalence estimates, and the data on the consequences of drug abuse, such as deaths, emergency room episodes, and treatment admissions. Comparatively little attention has been given to patterns and trends in the incidence of drug use.

The National Institute on Drug Abuse (NIDA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) of U.S. Department of Health and Human Services (HHS) sponsor several national surveys to track drug use trends. One of the most widely known is the National Household Survey of Drug Abuse (NHSDA), which interviews persons age 12 and older living in households about alcohol and illicit drug use. Any illicit drug use includes use of marijuana, cocaine, hallucinogens, inhalants, heroin, or non-medical use of sedatives, tranquilizers, stimulants, or analgesics.

According to NHSDA, between 1999 and 2001, illicit drug use during the past 30 days for persons 12 and older increased from 6.3% to 7.1%. Illicit drug use in the previous twelve months for persons 12 and older increased from 11.5% to 12.6%. In 2001, the percentage of Americans reporting marijuana use at least once in the past month was 5.4% of population age 12 and older. An estimated 0.7 % of the population age 12 and older also reported using cocaine including crack, at least once in the past month.²

Another source of information about national drug trends is the Drug Abuse Warning Network (DAWN) which is sponsored by SAMHSA, the federal agency which is required under Section 505 of the Public Health Service Act to collect such data.. DAWN relies on a sample of hospitals operating 24-hour emergency departments (ED) to capture data on ED visits induced by or related to substance abuse. DAWN data do not measure prevalence of drug use in the population, but the probability sample of hospitals is designed to produce representative estimates of ED drug episodes and drug mentions for the coterminous United States and for 21 metropolitan areas.

Nationally, the number of drug –related emergency department episodes increased from 323,100 in 1978 to an all time high 638,484 in 2001. In 2001, cocaine-related episodes were at their highest level since the DAWN survey began in 1978. They constituted 30% (193,034) of all emergency department drug –related episodes. Between 1990 and 2001, marijuana/hashish- related episodes increased 604% (from 15,706 to 110,512) Between 1990 and 2000 the number of heroin-related episodes increased 180% (from 33,884 to 94,804). In 2001, heroin-related episodes decreased slightly by 1.8% to 93,064.³

The DAWN data clearly indicates an upward trend nationally in the use of the major illicit drugs such as cocaine, marijuana and heroin.

Co-Occurring Disorders

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It is estimated that seven to ten million individuals in the United States have at least one mental and a behavioral disorder, such as alcohol or drug abuse (U.S. DHHS, 1999 SAMHSA National Advisory Council, 1998). Individuals experiencing these disorders simultaneously are referred to as dually diagnosed or having co-occurring disorders.

The National Institute of Mental Health's Epidemiologic Catchment Area Study reported that about 6% of the general population had a lifetime prevalence of co-occurring substance abuse and mental health disorders. In 1996, the National Comorbidity Study noted an increasingly higher prevalence of mental health and substance abuse and higher rates of co-occurrence disorders. Individuals with co-occurring disorders who do not receive integrated treatment have a greater risk of unemployment, homelessness, and inadequate health care. Lack of treatment combined with behavioral risk-taking from substance use and mental health disorders place these individuals at a greater risk for having a multitude of health related problems.⁴

APRA uses an integrated care approach in all of its programs to address multiple health problems and co-occurring disorders. We know that individuals with co-occurring disorders or are "dually diagnosed" have a greater risk of being unemployed, homeless and having multitude of health related problems.

APRA ensures that all clients receive a comprehensive bio-psycho-social assessment and responsive care plan that integrates medical, mental health, and social needs within an individualized addiction recovery strategy. The treatment counselor is the primary lead for developing the treatment plan. Over the last two years, APRA has co-located a primary medical care center and a mental health center within the APRA treatment system to ensure integrated care.

Substance abuse and Sexual Behavior

Another disturbing trend, which researchers have begun to explore, is the connection between alcohol usage and or drug use and sexual "risk behaviors"– activities that put people at increased risk for STDs, unintended pregnancy, and sexual violence. Risky sexual activities include using condoms inconsistently or having multiple sexual partners over one's lifetime. Studies conducted to date indicate that drinking and illicit drug use often occurs in association with risky sexual activity.

About two million adults – one man in 100 and one woman in 200 – admit to using drugs before having sex in the past year. Illicit drug users are also more likely than non-users to have multiple sex partners. One study found that 52 percent of those who used marijuana in the previous year had two or more sex partners during the same period, compared with sixteen percent of those who had not smoked pot. There is even more extensive research documenting the relationship between the use of crack or injection drugs and an increased number of sexual partners. People who are receiving treatment for alcohol and drug use or who use multiple drugs are more likely than others to engage

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in risky sexual activity. A study of alcoholics found that those who also have drug problems are more likely than those who do not to have multiple sex partners⁵

A national survey of Americans aged 18 to 59 found that 90 percent of men and 86 percent of women had sex in the year prior to the survey. More than 80 percent of adults had ever used alcohol and more than half have had a drink in the past month. Illicit drug use is less common, particularly among adults aged 35 and older. About half of adults aged 18-35 say they have ever tried an illicit drug, as have about a third of those 35 and older. Fifty-two percent of boys and 48 percent of girls in 9th to 12th grades report ever having sex and 36 percent of high school students say they have had sex recently. Seventy-nine percent of high school students say they have tried alcohol and more than half of all high school students in 1997 reported having used at least one illicit drug and a quarter reported frequent drug use.⁶

Increased alcohol use seems to be associated with an increased likelihood of sexual activity. When men aged 18 to 30 were asked to report their episode of heaviest drinking in the last year, 35 percent said that they had sex after consuming five to eight drinks and 45 percent had sex after consuming eight or more drinks, compared with 17 percent of those who had one or two drinks. Among women aged 18 to 30, 39 percent had sex while consuming five to eight drinks and 57 percent had sex when consuming eight or more drinks, compared with 14 percent of women who had one or two drinks.

There is some evidence that heavy alcohol use is associated with having multiple sex partners, which is a primary risk factor for transmission of STDs, including HIV. Seven percent of adults who report never drinking or drinking less than once a month say that they have had two or more sex partners in the last year, compared with fifteen percent of those who say they drink monthly, and 24 percent of those who drink weekly. Among adults aged 18 to 30, binge drinkers are twice as likely as those who do not binge drink to have had two or more sex partners in the previous year. (That is, seven percent of those who never binge drink compared with 40 percent of those who report monthly binge drinking.) This is true even after controlling for other factors – including age, sex, marital status, and drug use – that can affect a person's likelihood of having multiple sex partners. Heavy drinkers are five times as likely as non-heavy drinkers to have at least ten sex partners in a year.⁷

Sharing drug needles has long been known to be a primary route of the HIV/AIDS transmission. Drug use also contributes to the spread of HIV to people that have sex with a drug user and to children born to HIV-infected mothers who acquired the infection from sharing needles or having sex with an infected drug user. Injection drug use or sex with partners who inject drugs account for a larger proportion of female than male AIDS cases in the U.S. (59 percent and 31 percent respectively of all cases, since the epidemic began).

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Public health experts anticipate that creating a greater awareness of the potential relationship between substance use and risky sexual activity can influence individuals who rely on drinking or drugs to help reduce inhibitions, increase sociability, or enhance sexual arousal. Some people may drink or use drugs to gain courage, relieve pressure, or justify behavior they might otherwise feel is uncomfortable or unwise – without considering the potential consequences. In addition, determining how the use of alcohol or other substances influence sexual risk-taking can help to inform efforts by health care providers, educators, social workers, and policymakers to create effective programs for substance abuse prevention and treatment, STD and HIV prevention, and sexual health education

During FY2002 APRA continue to enhance access to early intervention programs (EIS) for clients with HIV/AIDS through specialized treatment programs, on-site counseling and testing at intake, increased sensitivity training of treatment staff, and referral to HIV service providers and coordination of services.

LOCAL TRENDS

In December 2000, APRA conducted the first-ever citywide household survey on substance abuse. A total of 1535 District households were surveyed and yielded some very useful information about current drug use and drug dependence in the District. The 2000 DC Household Survey found that 9.6% of residents, ages 12 and older, reported using an illicit drug in the past 30 days. Marijuana was the most prevalent illicit drug with 7% of residents 12 years or older reporting use within the past 30 days. Cocaine was second with 2% of the District's population 12 years and older reporting use within 30 days prior to the survey.⁸

The highest rate of illicit drug use in the District occurs within the age cohort of 18 to 24 years old. 20.5% of this age group reported illicit drug use within the past 30 days.⁹

The survey also revealed that prevalence of alcohol use was highest among residents 18 to 24 with 64.8% reporting use in past 30 days. About one out of every 6 adolescents (ages 12 to 17) or 17.2% reported current alcohol use within the past 30 days.¹⁰

With regard to tobacco use, 12.1% of youth ages 12 to 17 reported cigarette use within the past month. The rate for youth adults 18 to 24 reporting cigarette use in past 30 days jumps to 32%.¹¹

The DC Household Survey also found that the District's overall rates of substance abuse are 40% higher than the national rate for illicit drug use. The survey found that District

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youth initiate alcohol and tobacco use at much earlier age compared to the national average.¹²

However, the DAWN data from D.C. Emergency Departments (ED) for 1998 through 2001 indicates that ED episodes decreased from 11,596 in 1998 to 10,566 in 2001. The ED drug mentions for this period also decreased from 19,054 to 17,480. These decreases respectively of % and % may be reflective of a downward trend. Preliminary data for the first six months of 2002 continues to support this trend.¹³

Drug-related deaths and mentions reported to DAWN by D.C. medical examiners are also on a downward trend. Overdose deaths declined from 145 in 1998 to 53 in 2001. Eighteen deaths were caused by cocaine and four were due to heroin. The remaining deaths were due to a combination of drugs and alcohol. Total drug mentions declined from 243 to 88 during the same period.¹⁴

The number of people admitted to alcohol/drug treatment in Washington D.C. increased sharply from 3,618 in 1998 to 6,056 in 1999 and then declined to 5736 in 2001.¹⁵

The District's Court system provides a significant amount of information and data on drug and alcohol use in the District. There are two drug courts operating in the District. The district was the first city in the country to test arrestees for drug use as a condition of release. Pretrial Services Data and Arrestee Drug Abuse Monitoring (ADAM) data are useful for tracking and determining social indicators and patterns of substance abuse. The virtue of these data is that they are well established and have been available for many years.

Over half of adult and juvenile males arrested for violent or property crimes in the District tested positive for illicit drug use. During FY 2001, 37.8 percent of defendants sentenced in the District's Federal Court were charged with drug offenses. Crack cocaine was involved in 55.8 percent of the drug offenses. This is indicative of the insidious correlation between substance abuse and crimes such as, burglary, robbery, auto theft, assault, child abuse, and murder.¹⁶

Funding for Substance Abuse Services

An analysis conducted by the National Center on Addiction and Substance Abuse at Columbia University (CASA) of state's budgets revealed that of a total of the taxpayers dollars spent on problems related to substance abuse and addiction during 1998, only four percent was spent on treatment and prevention, while 96 percent was spent on clearing up the damage from substance abuse. In 1998, states spent \$81 billion on substance abuse

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an addiction or 13.1 percent of their total budgetary outlay. However, of each dollar spent only four cents was spent on actual treatment and prevention of the growing problem. Most of the dollars spent (\$30.7 billion) on “damage control” was used towards the justice system.

The Medicaid program accounts for a third of the public spending on mental health and substance abuse (MH/SA) treatment. Because it focuses on those in poverty and those with disabilities it is a particularly important program for adults with serious mental disorders and children with serious emotional disturbances.

Nearly all of the large U.S. employers, surveyed by Foster Higgins and the American Association of Health Plans (AAHP) cover mental health/substance abuse services, but not to the same extent as they cover other medical care. Most employers are likely to cover traditional forms of MH/SA services. For substance abuse services, most covered inpatient and outpatient detoxification treatment and outpatient therapy. About two-thirds covered intensive non-residential treatment, and case management and referral services, about a third covered non-hospital residential substance abuse care, whereas less than a fifth covered methadone maintenance.

Employers often restrict coverage of MH/SA benefits by placing more limits on their use and or imposing greater cost sharing than they do for other health care services. In a majority of plans these restrictions apply for both mental health and substance abuse services. Cost sharing may take the form of limits on annual or lifetime benefit payments or the use of deductibles, co-payments or co-insurance for services.

In 1989, 58 percent of the panel-surveyed employers had an Employee Assistance Program (EAP). Although originally designed to assist employees address personal problems, by the late 1980s, employers were increasingly integrating their EAPs with their health plans and having them serve as a “gatekeeper” function. By 1995, EAPs had increased and their role had changed. In that year, 81 percent of the panel respondents offered an EAP. A majority of the EAPs had a cost management/utilization review role.

The District of Columbia spent \$136.4 million in FY2001 on programs to reduce substance abuse in the city. Law enforcement and corrections programs accounted for 56% or 77 million, while spending on substance abuse treatment, prevention, testing totaled 60 million or 44% of the total spending amongst the various city agencies.

These direct expenditures do not reflect the total cost of services to individuals who abuse addictive substances. There are indirect expenditures such as the shelter cost for individuals that are homeless because of their substance abuse problems, the cost of treating other health consequences of substance abusing individuals such as hepatitis, liver diseases, HIV/AIDS, lung diseases and the cost of child protection services due substance abuse in the family.

The concept of direct and indirect expenditures illustrates the fact that the consequences of substance abuse, far exceeds the cost of prevention.

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The District is continuing its efforts to maximize third party reimbursements. Until 1994 District funded substance abuse treatment was considered to be in the “Public Interest” and was provided free, regardless of the client’s ability to pay, because of the benefit to the general public. This provision hampered the District efforts to collect fees from clients that could afford to pay or collect from third party payers, such as, Medicaid, or private insurers. In October 1994, the City Council passed legislation which authorized APRA to implement a fee-for-service payment system for clients in the methadone treatment program.

Currently, APRA’s central intake process includes a financial review function to determine a client ability to pay based on a sliding fee scale. The intake process also includes a determination of eligibility for Medical Assistance (MA) and preparation of the MA application, if appropriate. The process also facilitates the billing of other third party insurers for which the client may be eligible. It is estimated that self-pay fees and MA reimbursements could generate an additional 6 million dollars to offset the cost of substance abuse treatment.

Quality Issues

The District implemented mandatory licensing and certification standards for all substance abuse treatment facilities and programs in September 2000. These regulations require every substance abuse treatment program in the District to develop and implement a Continuous Quality Improvement (CQI) plan to establish and maintain a comprehensive quality improvement process through the program’s professional and administrative staff that will monitor the quality indicators of service delivery and outcomes. These regulations also include specific core service requirements for types treatment settings and services.

In FY2001, APRA conducted independent peer reviews to assess the quality and efficiency of treatment services. Programs were reviewed and reports generated to highlight strengths and weaknesses and to monitor implementation of recommendations. The peer review and other performance improvement function were modeled on successful systems in similar states. The APRA peer review committee is comprised of staff representing the various disciplines involved in direct treatment services, such as physician, social worker/case manager, registered nurse and certified addiction counselor.

For FY2003 the APRA Office of Quality Improvement will design a new peer review protocol for use in all publicly funded programs. The protocol will include an instrument of tool, schedule, delineation of the credentials and qualifications of the clinical review team members, report format, and procedures for responses and corrective action. All publicly funded treatment programs are required to participate in the peer review process. APRA is responsible for forming the peer review teams as well as a Performance Improvement Committee.

APRA also has a Medical Records Committee that is responsible for developing and monitoring policies and procedures to prevent inappropriate access and disclosure of client information. This committee is currently reviewing all of APRA policies and

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procedures regarding the privacy of client information to ensure compliance with the new HIPAA requirements.

III. SUMMARY OF RESOURCES AND UTILIZATION OF SERVICES

Resources

Health Care Professionals

Health care professionals that are most often involved with substance abusers include clinical social workers, physicians, psychiatrists, psychiatric nurse practitioners and counselors. In a random survey conducted by Practice Research Network (PRN) of 2,000 National Association of Social Workers (NASW) members, it was found that a large involvement of members across all settings in diagnosing, screening and treating substance abuse. 71 percent of social workers dealt with substance abuse. In 2001, 43 percent of social workers performed screening for substance abuse, 26 percent diagnosed it, 19 percent treated primary substance abuse, 47 percent treated secondary substance abuse, 61 percent referred clients to substance abuse treatment and 11 percent screened for compulsive gambling. The survey also found that social workers in organization settings treat more patients with substance abuse problems or with both substance abuse and alcohol problems than do private practitioners.

The ability to attract and retain experienced healthcare professionals in public treatment programs is a major issue. Low pay scales are resulting in high staff turnover rates in many programs. Public treatment programs are losing experienced staff to higher paying private programs and are left with inexperienced workers. This has an adverse effect on efforts to improve the quality of treatment services in these programs.

There is a dearth of case managers/social workers and bilingual staff in the public treatment programs. The case management functions are currently provided by the certified addiction counselor as part of their job description with the support of social service assistants.

Utilization of Services

Public and Private Treatment Facilities

The number of publicly funded treatment slots available in FY2000 for substance abuse treatment was 3,747. The Addiction Prevention Recovery Administration (APRA) has a daily census reporting system, which enables APRA to monitor the client utilization of the treatment services and enhance capacity management. There is a waiting list for 116 clients for methadone outpatient treatment due to increased demand by intravenous drug users for treatment.

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During FY2002 a total 11,043 clients were served in public treatment programs. For the first quarter of FY2003 a total of 3,930 clients have been served.

All substance abuse treatment programs or facilities that offer or propose to offer non-hospital residential, non-hospital detoxification, or outpatient treatment in the District must be certified by the Department of Health in accordance with the standards set forth under Chapter 23 in Title 29 of the District of Columbia Municipal Regulations (DCMR).

According to APRA, Eighty- three substance abuse treatment facilities/programs have submitted applications for certification. Fifty-three of the facilities are private sector non-profit or profit programs. The remaining thirty facilities are publicly funded programs through contracts from the District government. The majority of these providers offer treatment services in a residential or outpatient setting, which is more cost effective than the inpatient setting.

As of May 1, 2003, sixteen substance abuse treatment programs had been certified by DOH under Chapter 23 in Title 29 of the DCMR

APRA is also responsible for certifying substance treatment programs for participation in The Drug Treatment Choice Program under Chapter 24 in Title 29 of the DCMR. This is a voucher program for substance abuse services, which was implemented by APRA in FY 2003 as a result of the “Choice in Drug Treatment Act of 2000”. This program is designed to enhance access to publicly funded treatment services by expanding the pool of treatment providers that meet the eligibility criteria established under the Act’s certification standards. As of May 1, 2003, APRA had certified twenty treatment facilities/providers for participation in this program.

The number and location of residential and outpatient treatment programs which have applied for certification in the District of Columbia are detailed in the appendix and includes for some programs, the number of clients served in FY 2002, static treatment capacity, the type of treatment setting/services offered and certification status.

IV. NEED PROJECTIONS OF SERVICES

APRA, as the Single State Agency (SSA) for substance abuse in the District of Columbia collects and analyzes a variety of data for its continuous assessment of need for prevention interventions and treatment services. APRA staff uses U.S. Census estimates of the local population and of the sub-state units (wards), including annual and biennial updates generated by the District’s Office of Planning. APRA staff review changes in population size, age, and racial/ethnic composition and the distribution across wards to identify broad trends that have implications for program planning.

Sub-state planning and need projection is based on the District’s 8 wards, which are the political and administrative subdivisions of the District and are the basis for the District’s elected legislature, the City Council. The wards vary considerably with regard to socio-demographic characteristics and other factors associated with substance abuse such as ,

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income, poverty ,racial/ethnic composition, age distribution, crime, mortality and morbidity, housing conditions, and quality of neighborhoods.

APRA staff also review annual findings from the NHSDA, The National Survey of Substance Abuse Treatment Services (N-SSATS), DAWN, the Behavioral Risk Factor Survey and the biennial Youth Risk Factor Survey for information on current prevalence trends, changes in prevalence and incidence, and information on factor contributing to or resulting from substance abuse. APRA also analyzes data from the Metropolitan Police Department and the Department of Corrections. Information on arrests for drug possession and use are used by APRA to identify those neighborhood most affected by substance abuse as well as trends in prevalence of the type substance abused

The 2000 Census placed the unadjusted population of the District at 572,079. Several changes in the characteristics of this population are particularly relevant for substance abuse planning. During the 1990s the Latino population increased 37.4% and currently represents 8% of the District's population. Ten percent of the District's children are Latino. The Asian/Pacific Islander population increased from 1.8% to 2.8% of the city's population. Although 60% of the District population remains African American, 13% is foreign born and 17% older than the age of 5 speak languages other than English at home, an increase from 10% in 1990.

Only 41% of the District's housing are owner-occupied, ranging from 21% in Ward 8 to 62% in Ward 4. thirteen percent of households are headed by females with related children. The prevalence of female-headed households varies from 2.1% in Ward 3 to 33% in Ward 8. The 2000 Census also indicated the number of adults and children living below the Federal Poverty Level (FPL) increased significantly from 1990. The 1990 census indicated that 17% of the District's adult and 25% of the children were below the FPL, while the 2000 census indicated 20% of adults and 31% of children were below the FPL.

APRA contracted with Westcom International, Inc in 2000, to conduct a survey of the District's households to provide ward-level estimates of the prevalence of abuse by type of substance and age group. In September 2001 the findings of this survey confirmed that use of alcohol, tobacco and illicit drugs varies across wards as well as age groups. Past month use of cigarettes, for example, ranged from 7.8% in ward 4 to 41.8% in Ward 8. Use of illicit drugs varied from 2.7% in Ward 3 to 14.1% in Ward 2. Use of alcohol ranged from 20.5% in Ward 4 to 76.5% in Ward 3.

While the problem of substance abuse transcends ward boundaries and demographic characteristics, some groups have more resources to deal with its individual, familial, and neighborhood impact. Employed persons may have access to employee assistance programs or have health insurance that provide substance abuse treatment benefits. Higher income families may be able to pay out-of-pocket charges for treatment

APRA uses quarterly performance data to compiled by the District's State Center for Health Statistics to track changes public health indices and service delivery. Data relevant

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to planning for substance abuse programs include deaths attributed to alcohol and other drugs, infant mortality rates, maternal and child health indicators, homicides and certain cancers. The DC Healthy People 2010 planning process includes an annual implementation plan, which focuses on primary prevention of substance abuse through the use of information campaigns and enrichments programs targeted towards youth.

According to Healthy People 2010 goals, the number of slots available in 2010 for substance abuse treatment should be increased from 3747 to 3977 (an addition of 230 slots). For women and women with children the number of slots available in 2010 should be increased from 435 to 550 (an addition of 125 slots).

Although the District's population can readily access most programs and treatment sites across ward boundaries, methadone treatment slots are limited. APRA will continue to focus prevention efforts and expansion of treatment programs in Wards 5,7, and 8 where the overall unmet need appears to be the greatest. In addition, APRA will focus programs for the Latino population in Ward 1.

V. CRITERIA AND STANDARDS

In general, the comprehensive substance abuse and prevention delivery system subscribes to the philosophy that treatment should be: structured, long-term, multidisciplinary, flexible, compassionate and family oriented.

Availability

Availability of care may be defined as the presence of enough numbers of substance abuse providers and facilities to meet the health care needs of people diagnosed with substance abuse disorders in a particular jurisdiction, such that clients do not have to travel outside their jurisdiction for care. A full range of alcoholism and drug abuse services, including all aspects of prevention, treatment, and aftercare should be available. The capacity of the treatment system should be adequate to meet the demand for treatment and should include the needs of special populations to avoid lengthy waiting periods for treatment.

Accessibility

Accessibility of care, often referred to as access, should not be confused with availability of care. Accessibility is measured by the presence or absence of health insurance, the high cost of care, physical distance between client and his/her provider, inconvenient clinic hours, language and cultural barriers, or a lack of sensitivity by care providers.

All substance abuse programs must provide access to services free from all barriers. No barriers (architectural, communication, procedural, or financial) to the delivery of services shall exist. All programs must ensure equal access to qualified handicapped individuals, including individuals infected with HIV/AIDS.

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Continuity

Treatment has a greater probability of effectiveness if all services in the continuum of care are available to the client. The continuity standards for substance abuse treatment services are as follows:

- The treatment and care of a client should include diagnosis and assessment of the client's physical and mental health, medical detoxification when indicated, determination of an appropriate treatment modality, transitional care services, aftercare/follow-up services, and any necessary support services.
- Programs offering treatment for alcohol/drug dependency and abuse must directly provide or make available through formal referral arrangements the full range of needed services for each client.
- Substance abuse treatment services should incorporate counseling, diagnosis, treatment and follow-up support services for HIV-infected individuals.

Continuity of care for alcohol and drug dependency may be adversely affected by third-party reimbursement and other insurance mechanisms. Both private and public insurance coverage may limit treatment by placing annual and lifetime caps on substance abuse and mental health benefits and by limiting inpatient days. Outpatient and aftercare services are often not covered benefits.

Quality

The standards for quality of substance abuse services are outlined in the District's Certification Standards for Substance Abuse Treatment Facilities and Programs. These standards require each substance abuse treatment program to implement a Continuous Quality Improvement (CQI) process into its organizational structure and service delivery system as follows:

- Establish a quality improvement plan and staff to coordinate and implement the CQI process on a quarterly basis
- Involve interdisciplinary teams of treatment staff and management to monitor administrative and patient records to ensure compliance with key quality indicators of care and provide appropriate training of all personnel
- Monitor utilization of services and treatment outcomes
- Document all findings and corrective actions

Acceptability

The standards for acceptability for substance abuse treatment services are as follows:

- Providers should be sensitive to the special needs of the consumer and should ensure that the program design is acceptable and does not inhibit those in need from seeking treatment.

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- The selection of treatment modality and setting and availability of support services should be conducive to patient cooperation and participation. Program design should include appropriate referral mechanisms and staff to minimize language and cultural barriers.

The “Choice in Drug Treatment Act of 2000” provides District residents with access to a treatment provider of their choice in consultation with a qualified substance abuse counselor and subject to the availability of funds. All treatment providers must be certified under Title 29, Chapter 24 of the District of Columbia Municipal Regulations (DCMR) in order to participate in this program

Cost

The standards for cost of substance abuse treatment service are as follows:

- Program design should ensure that the maximum amount of treatment is provided at a minimal administrative cost.
- Proposals for new or expanded inpatient treatment should demonstrate that less costly alternatives are not feasible or appropriate for the target population.
- Applications for Certificate of Need shall demonstrate the financial feasibility for their projects and provide cost estimates along with revenue projections. Revenue projections shall be broken out by Medicare, Medicaid, private and other sources.
- All substance abuse programs are required to adhere to minimum financial management standards and document the program’s financial resources and sources of future revenue in order to be certified in the District.

VI. GOALS AND OBJECTIVES

Goal 1: Educate and empower District of Columbia residents to live healthy and drug-free lifestyles.

Objectives:

1. *Utilize a broad cross-over advisory group to develop policy, coordinate and leverage available resources relative to youth substance abuse.*
2. *Promote and fund evidence and science based prevention programs in the six domains; individual, peer, family, school, community and the larger societal environment.*
3. *Support comprehensive community center programs for youth and their families, who may have dropped out of school or interfaced with the juvenile justice system.*
4. *Create peer-to-peer programs to enable trained teens to help their peers to make healthy choices to live drug free lifestyles.*
5. *Provide training to youth development and prevention professionals to implement effective prevention strategies.*
6. *Expand the use of commercial marketing techniques to influence attitudes and change behavior in support of healthy lifestyle decision-making*

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7. *Maximize the media to increase awareness of the cost of substance abuse to the individual and the community*
8. *Restrict youth access to alcohol and tobacco*

Goal 2: Develop and maintain a continuum of care that is efficient, effective, and accessible to those needing substance abuse treatment.

Objectives:

1. *Increase treatment capacity, especially for youth and women with children.*
2. *Enforce compliance with accreditation and certification standards for all substance abuse treatment programs*
3. *Provide technical assistance and training to treatment staff to enhance development and treatment infrastructure.*
4. *Develop performance accountability system for all treatment programs which will enhance continuous quality improvement*
5. *Continue to enhance and promote integrated treatment services and strategies for individuals with co-occurring disorders.*

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VII. REFERENCES

1. First Citywide Comprehensive Substance Strategy for The District of Columbia, April 24 2003 pg 1-1
2. Office of National Drug Control Policy Information Clearinghouse Fact Sheet “ Drug Use Trends October 2002 “
3. Ibid
4. Metropolitan Council of Governments The Forum Vol. 3, Issue 1 Fall 2002 “ On Co-Occurring Mental Health and Substance Abuse Disorders”
5. Substance Use and Sexual Health Among Teens and Young Adults in the U.S. Henry J. Kaiser Foundation.
6. Ibid
7. Ibid
8. District of Columbia 2000 Household Survey On Substance Abuse, September,2001
9. Ibid
10. Ibid
11. Ibid
12. Ibid
13. ONDCP Drug Policy Information Clearinghouse “Washington, DC Profile of Drug Indicators” March, 2003
14. Ibid
15. SAMHSA Treatment Episode Data Set (TEDS) January, 2003

VIII. APPENDIX

TREATMENT FACILITIES BY TYPE OF SERVICE, CERTIFICATION STATUS, CAPACITY AND CURRENT CAPACITY

Treatment Program	Type of Service	Treatment Capacity	Number of Clients Served in FY2002	Certification Status
1. Psychiatric Institute (Lambda Center) 4228 Wisconsin Ave. NW	Residential treatment of sexual minorities	6	88	Full-Chapt.23 Prov-Capt 24
2. RAP Nurture for Life Continuum 1949 4 th St. NE	Residential treatment for women and dependent children	11	138 women w/children	Pending
3. RAP 120- day Treatment for Alcohol and Drugs 1949 4 th St NE	Residential Treatment	42	297	Pending
4. Salvation Army 2100 N.Y. Ave NE	Residential	164	61	Full-Chap-23
5. Community Action Group/Holy Comforter 16 17 th St NE	Residential	24	New	Prov-Chap-23 Prov-Chap-24
6. Vanguard Services Unlimited (Demeter) 301 I St NW	Residential for women & children	10	109	Full-Chap-23 Ful-Chap-24

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7. 24 th Place Aftercare 24 th Pl NE	Outpatient Aftercare	50	45	Pending
8. Gospel Rescue Ministries 810 5 th St NW	Outpatient	82	unavailable	Pending
9. Andromeda Latino Abstinence 3601 14 th St. NW	Outpatient Abstinence	65	316	Pend-Chap23 Prov-Chap 24
10. Shaw Abstinence Program 33 N St. NE	Outpatient Abstinence	50	175	Pending
11. Adams Mill Abstinence Center 1808 Adams Mill Rd. NW	Outpatient Abstinence	50	154	Pending
12. Latin American Youth Center 1419 Columbia Rd. NW	Outpatient	50	77	Full-Chap-23
13. Whitman Walker Latino 1407 S St. NW	Outpatient Abstinence	30	72	Pend-Chap 23 Full-Chap-24

14. Model Treatment 1300 1 st St. NE	Methadone Outpatient and interim treatment	550	983	Pending
15. Providence Hosp. UMOJA 5141 Nannie Helen Burroughs Ave. NE	Methadone Outpatient	400	552	Full-Chap 23 Full-Chap-24
16. Women's Services Clinic 1905 E St. SE	Methadone Outpatient	300	423	Pending
17. UPO 33 N St. NE	Methadone Outpatient	300	368	Full-Chap 23 Full-Chap-24
18. Dept of Mental Health (CTI Bldg) 2700 MLK Ave. SE	Outpatient Dually Diagnosed	150	209	Pending
19. Concerned Citizens 601 Raleigh Pl. SE	Outpatient	30	120	Pend-Chap-23 Prov-Chap 24
20. Adult Abstinence Program 3720 MLK Ave. SE	Outpatient	50	135	Pending
21. Neighbors Consejo 1634 Lamont St. NW	Outpatient	10	52	Full-Chap-23 Full-Chap-24
22. Whitman Walker (Sexual Minority Abstinence) 1407 S St. NW	Outpatient	115	234	Pend-Chap-23 Full-Chap-24
23. La Clinical Del Pueblo 1470 Irving St. NW	Outpatient	25	165	Pend-Chap23 Prov-Chap 24

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24. Hillcrest Children's Center (Riverside) 4460 MacArthur Blvd NW	Youth Outpatient	18	25	Full-Chap23 Prov-Chap24
25. Institute for Behavioral Change 34 O St. NW	Outpatient	20	28	Pending
26. Federal City Recovery 425 2 nd St NW	Outpatient	90	Unavailable	Pending
27. Psychiatric Institute (Adult & Youth) 4226 Wisconsin Ave NW	Medical Detoxification	6	167	Full-Chap23
28. Federal City Recovery 2806 Pomeroy Rd SE	Outpatient	14		Pending
29. Howard Univ. Hospital 2041 Ga. Ave NW	Outpatient	Currently unavailable	Unavailable	Pending

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30.PIDARC Ste 101 2112 F St NW	Outpatient	500	Unavailable	Full-Chap23 Full-Chap24
31. Pilgrims Rest 4606 Sheriff Rd NE	Outpatient	30		Pend-Chap23 Prov-Chap24
32.Greater Mt. Calvary/ CATAADA House 802 R.I. Ave NE	Outpatient	50		Pend-Chap23 Prov-Chap24
33.Institute for Behavioral Change 401 H St NE	Outpatient	80		Pend-Chap23 Prov-Chap24
34.Seton House 1053 Buchanan St NE	Outpatient	100		Full-Chap23 Prov-Chap24
35. Holy Comforter/Community Action Group (CAG) 1238 Pa. Ave SE	Outpatient	25		Pend-Chap23 Prov-Chap24
36. Holy Comforter/CAG Women & Children 3321 13 th St SE	Residential	40		Pend-Chap23 Prov-Chap24
37. Cornell Abraxas Group 545 8 th St SE	Outpatient	40		Pend-Chap23 Prov-Chap24

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38. Horizon Therapeutic 1215-C S. Cap. St SE	Outpatient	80		Pending
39. Hillcrest Children Center/Turning Point 1325 W St. NW	Outpatient	10		Pend-Chap23 Prov-Chap24
40. Acme Symbas Team 3720 MLK Ave. SE	Outpatient	25		Pending
41. American Recovery Mgmt Ste. 510 236 Mass. Ave NE	Outpatient	25		Pending
42. Anchor Mental Health 1001 Lawrence St NE	Outpatient	Unavailable		Pending
43. Bibleway Church 1101 NJ Ave NW	Outpatient	100		Pending
44. Foundation for Contemporary Mental Health STE 404 2112 F St. NW	Outpatient	100		Pending
45. Bureau of Rehab. (Shaw) 1740 Park Rd NW	Residential	13		Pending

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46. Calvary Women's Shelter 928 5 th St NW	Residential	25		Pending
47. Center for Life Enrichment 1322-24 G St	Outpatient	30		Pending
48.Center for Mental Health 2041 MLK Ave SE	Outpatient	100		Pending
49. CMAC, Inc. Oasis 910 Bladensburg Rd NE	Outpatient	900		Pending
50.Coates and Lane 150 Seaton Pl NW	Outpatient	Currently Unavailable		Pending
51.Community Action Group/Holy Comforter 1900 M St NE	Residential	25		Pending
52.Comp Alcohol and Drug Counseling 575 Ritchie Rd	Outpatient	60		Pending
53. Whitman Walker Women's Health 1734 14 th St NW	Outpatient	30		Full-Chap23
54. Dept of Correction DC Lifeline 1901 E St SE	Residential	800		Pending

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55. Executive Addictive Disease Programs 4335 Wisc. Ave NW	Outpatient	32		Pending
56. Family & Medical Counseling Ste M 2041 MLK Ave SE	Outpatient	295		Pending
57. Federal City Recovery-Horner 3717 Horner Pl	Residential	25		Pending
58. Federal City Recovery-Bellevue 920 Bellevue St SE	Outpatient	25		Pending
59. Georgetown Medical Center 3800 Reservoir Rd NW	Outpatient	Currently unavailable		Pending
60. Whitman Walker Max Robinson 2301 MLK Ave. SE	Outpatient	15		Full-Chap23
61. Gospel Rescue Ministries 810 5 th St NW	Residential	34		Pending
62. Whitman Walker Bridge Back Center 4800 Ark. Ave NW	Residential	8		Full-Chap23
63. Insight 420A 8 th St SE	Outpatient	200		Pending

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64. Just Enough So You Stop Ste 120 316 F St NE	Outpatient	25		Pending
65. Kolmac Clinic Ste 703 1411 K St NW	Outpatient	80		Pending
66. Lutheran Social Services 4406 Ga. Ave NW	Outpatient	200		Pending
67. Mickey Leland House 1620 N. Cap NW	Residential	Unavailable		Pending
68. N Street Village 1333 N St NW	Outpatient	20		Pending
69. Professional Guidance Assocs. Ste 504 1301 20 th St NW	Outpatient	Unavailable		Pending
70. Progressive Life Center Inc. 1123 11 th St	Outpatient	50		Pending
71. PSI Associates Inc 770 M St SE	Outpatient	50		Pending
72. Safe Haven Outreach Ministries (Buckman) 931 Potomac Ave. SE	Residential	25		Pending

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73.Safe Haven Outreach (Sibley) 1140 N. Cap NW	Outpatient	80		Pending
74.Salomom Zelaya Rehabilitation 1345 Newton St NW	Residential	6		Pending
75. Samaritan Inn 1640 Columbia Rd NW	Residential	120		Pending
76.Samuels Christian Svcs Network 3316 NH Ave NW	Residential	40		Pending
77.Second Genesis Outpatient 1318 Harvard St NW	Outpatient	48		Pending
78.Second Genesis Residential 1320 Harvard St NW	Residential	49		Pending
79. SOME 60 O St NW	Outpatient	100		Pending
80.Terrific Inc. 1222 T St NW	Outpatient	Unavailable		Pending
81.Wash Assessment & Therapy Ste A-400 4455 Conn. Ave NW	Outpatient/Dually- Diagnosed	Unavailable		Pending

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82. Washington Hospital Center 110 Irving St NE	Outpatient	45		Pending
83. Whitman Walker Clinic 701 14 th St NW	Outpatient	50		Full-Chap23